

Area Regional Transit Paratransit Eligibility Medical Verification Forms

Please ask your Florida Licensed/Certified Health Care Provider to complete the medical form that best describes your need for Paratransit services.

Note to Medical Provider: By completing and signing the medical documents, you certify to the truth and accuracy of the information provided on the application, to the best of your professional knowledge. The Americans with Disabilities Act of 1990 requires ART to provide services to persons who are unable to use the fixed route bus system due to a disability. The information you provide will allow ART to make an appropriate evaluation of your clients' eligibility.

To qualify for Paratransit service, an individual must meet the criteria as set forth in one of the following categories:

Category 1: Individuals who, as a result of a physical or mental impairment (including visual impairments) and without the assistance of another individual (except the operator) cannot board, ride or disembark from an accessible transit vehicle.

Category 2: Individuals who can independently use accessible vehicles, but none are available on their route.

Category 3: Individuals who have a specific impairment-related condition that prevents them from independently getting to/from a stop.

Located at www.slcart.org, you may submit additional completed verification forms as applicable:

Form A - General Medical

Form B - Vision

Form C - Epilepsy or Seizure Disorders

Form D - Cognitive or Mental Health Conditions

ATTACH A COPY OF YOUR VALID FLORIDA DRIVER'S LICENSE/ID OR CURRENT GOVERNMENT ISSUED ID WITH THIS APPLICATION.

Area Regional Transit Paratransit Eligibility
Form D: Cognitive or Mental Health Conditions

To be completed by a Licensed Mental Health Care Provider

Applicant's Name: _____ Date of Birth: _____

1. Please state the name of the applicant's diagnosis from the DSM? _____

2. Date of onset? _____

3. Would applicant be able to travel independently on fixed route buses if they are medication compliant? ☐ Yes ☐ No

4. Check any of the following that is affected by the individual's disability?

<input type="checkbox"/> Orientation	<input type="checkbox"/> Concentration	<input type="checkbox"/> Monitoring time
<input type="checkbox"/> Problem-solving	<input type="checkbox"/> Coping Skills	<input type="checkbox"/> Judgment
<input type="checkbox"/> Short term memory	<input type="checkbox"/> Communication	<input type="checkbox"/> Gait or balance
<input type="checkbox"/> Long term memory	<input type="checkbox"/> Consistency	<input type="checkbox"/> Social behavior
<input type="checkbox"/> Aggression	<input type="checkbox"/> Performance	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Other: _____		

5. Is the applicant's functional limitation permanent? ☐ Yes ☐ No
If no, expected duration? # of Months _____ # of Years _____

6. For safety reasons, does the applicant need to travel on ART at all times, with a PCA? ☐ Yes ☐ No If yes, please explain:

7. For safety reasons, can applicant be left unattended at pickup or drop-off locations? ☐ Yes ☐ No If no, please explain:

I certify the information provided above is correct.

Signature of Licensed Mental Health Care Provider Date

Clearly print your contact information below:

Name: _____ Board cert. # or Lic. #: _____
Phone #: _____ Fax #: _____
Business address: _____